

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN8201</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/29/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRISTOL NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>261 NORTH STREET BRISTOL, TN 37625</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	<p>1200-8-6 No Deficiencies</p> <p>This Rule is not met as evidenced by: During the complaint investigation # 30371, conducted on August 29, 2012, at Bristol Nursing Home, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.</p>	N 002			

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

5599

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If continuation sheet 1 of 1